Authority

Federal: Title XXI of the Social Security Act, Public Law 89-97, as amended
State: Title 32.1, Chapter 13, *Code of Virginia*

Establishment of the National Children's Health Insurance Program

The Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP) under Title XXI of the *Social Security Act*. The program, which is voluntary, became effective on October 1, 1997. Under it, states may extend health insurance coverage to uninsured children under age 19 living in families with incomes below 200 percent of the federal poverty line who are not eligible for Medicaid. Three options are available to states for increasing coverage under CHIP: expand Medicaid, establish a new insurance program separate from Medicaid, or implement a combination of both. State must supply matching funds, but the required matching rates are lower than Medicaid rates.

The program attempts to improve children's access to health care by covering some of the 11.3 million children under age 19 that were estimated to be uninsured as of 1997. An analysis by The Commonwealth Fund based on the March 1997 *Current Population Survey* estimated that nearly half of all uninsured children--5.1 million-were eligible for Medicaid based on their poverty status and age. Another 4 million could become eligible under CHIP, including approximately 1.1 million children ages 14 through 18 who will become eligible for Medicaid with planned expansions over the following four years. Together, the programs hold the potential of covering eight out of 10 uninsured children under age 19.

By September 1999, all 50 states, the District of Columbia and five U.S. territories had adopted CHIP programs and received the necessary approvals from the Center for Medicare and Medicaid Services (CMS). Two-thirds of the states have used the increased flexibility to explore alternatives to Medicaid and have created or expanded non-Medicaid programs. Of the 51 CHIP plans set forth by each state and the District of Columbia, 18 expand Medicaid, 17 create programs separate from Medicaid, and 16 do both. Nearly every state has taken advantage of the program to provide expanded health care coverage to children in low-income families. Information developed by The Urban Institute shows that forty-five states expanded coverage for infants, 49 states expanded coverage for children ages 1 to 6, and 50 expanded coverage for children ages 6 to 15.

Establishment of the Virginia Child Health Insurance Program

Chapter 464 of the 1998 Virginia Acts of Assembly authorized the establishment of Virginia's Child Health Insurance Program known as the Children's Medical Security Insurance Plan (CMSIP) and directed the Department of Medical Assistance Services (DMAS) to promulgate regulations to implement the program to be effective July 1, 1998. Some 63,200 children were projected to be enrolled in the program when it reaches maturity. Virginia submitted its plan for a separate program, CMSIP, to CMS for approval on June 12, 1998. The CMSIP program was described as a separate program, but a Medicaid look-alike program. HCFA approved the plan on October 22, 1998.

Establishment of the Virginia Child Health Insurance Program (Continued)

In 2000, the General Assembly made changes in CMSIP to create the Family Access to Medical Insurance Security (FAMIS) program, which changed not only the name of the program but also changed the program from a Medicaid look-alike program to a program modeled after the private sector. A revised Title XXI plan was submitted and approved by CMS on December 22, 2000. Effective August 1, 2001, a separate application for FAMIS was implemented and a central processing unit with a call center was established for receipt and processing of FAMIS applications only. The income eligibility was simplified by raising the income limit to 200% of the Federal Poverty Level and gross income was used in the financial calculation. A new benefit package was introduced along with premiums and co-payments. The Employer Sponsored Health Insurance component of the program was implemented. The Title XXI program's association with local departments of social services and Medicaid was severed.

In 2002, due to low enrollment in the Title XXI program and the difficulty families experienced navigating two different programs, the General Assembly directed DMAS to revise the program to facilitate enrollment. Effective September 1, 2002, the State began operating a combination Title XXI program, a Medicaid expansion as well as a separate program. Medicaid eligibility was expanded to 133% of the Federal Poverty Level for children 6-19 and FAMIS began covering children with gross family income in excess of 133% but less than or equal to 200% of the Federal Poverty Level. A combined application for Children's Health Insurance was developed and a "no wrong door" policy was implemented. Applications for Children's Health Insurance are accepted at the local departments of social services in the city of county where the child resides as well as the FAMIS central processing site. Verification requirements for both Medicaid and FAMIS were streamlined, and to the extent possible, made uniform. In addition, monthly premium payments were suspended and, later, were deleted from the program.

Eligibility for the Program

Children may be eligible for FAMIS if:

- They are ages 0 through 18,
- They are residents of Virginia,
- They meet the citizenship/alienage requirement,
- They live in families with gross income at or below 200% of the Federal Poverty Level,
- They are uninsured or have not had private health insurance for the past six months,
- They are not eligible for Medicaid,
- Their parents are not employed by a public agency with access to State Employee Health Insurance.

Services Covered by FAMIS

Children enrolled in FAMIS receive a comprehensive set of medical and dental benefits, including:

- Hospital Care
- Outpatient Care
- Physician Services
- Surgical Services

Services Covered by FAMIS (Continued)

- Outpatient Mental Health Services
- Inpatient Mental Health Services in a psychiatric unit of a general acute care hospital
- Laboratory and Radiological Services
- Prescription Drugs
- Home and Community-Based Health Services
- Clinic Services
- Dental Care Services
- Prenatal Care Pre-Pregnancy Family Services
- Ambulance Services
- Services for Special Education Students
- Hospital Emergency Services
- Durable Medical Supplies and Equipment
- Vision Care
- Abortion Services (only if necessary to save the life of the mother)
- Well-Child Care
- Rehabilitation Services
- Transplantation Services
- Hospice Services
- Nursing Services
- Early Intervention Services

Examples of Services Not Covered by FAMIS

Services not covered by FAMIS include:

- Inpatient Psychiatric or Psychological Services in a free-standing psychiatric hospital
- Friday or Saturday hospital admissions for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized
- Weight loss clinic programs
- Telephone consultation
- Hospital charges and inpatient physician services for days of care not authorized for coverage
- Abortions, unless necessary to save the life of the mother
- Sterilization
- Medical care received from providers not authorized by DMAS or who will not accept payment from DMAS as payment in full

Eligibility Determination

Eligibility is determined by the FAMIS central processing unit and the local departments of social services located throughout the Commonwealth. The FAMIS central processing unit handles ongoing case management for FAMIS recipients. Applicants become eligible for the program on the first day of the month in which the application was received if the applicant met all eligibility factors in that month. Eligibility continues for 12-months so long as the child meets all eligibility requirements. The parent or legal guardian of the recipient must report all changes affecting eligibility when they occur. A change in eligibility is effective the first of the month following the month the child is determined to be ineligible. Eligibility is redetermined no less often than annually. If the child becomes an inpatient in an institution for mental disease or an inmate of a public institution, ineligibility is effective the date that the child is admitted to the institution.

Providers and Provider Reimbursement

Services are delivered through HMOs under contract with DMAS in areas of the Commonwealth where FAMIS HMOs exist and through providers who are reimbursed on a fee-for-service basis in other areas of the State. Reimbursement is largely based upon rates established for the Commonwealth's Title XIX Program. Reimbursement differs from Medicaid in the following respects:

- Payments made for inpatient hospital services, outpatient hospital services, Federally Qualified Health Center and Rural Health Clinic services, inpatient mental health services, outpatient rehabilitation services, and outpatient substance abuse services are final. There are no retrospective cost settlements.
- Reimbursement for inpatient hospital services and inpatient mental health services does not include payments for disproportionate share or gradate medical education made to hospitals in the Medicaid program.

Program Data and Statistics

Statistics on enrollment in the program and payments made for services provided to recipients are shown in the following pages.